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| 医療機関  コード | | | | | | | | | |  | | | | |  | | | |  | | | |  | | | | |  | | | | |  | | | |  | | |  | | | |  | | | |  | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| 受給者証番号 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 区 | | | | | 診療年月 | | | | | | | | | | | | 診療  実日  数 | | | | | 保険  種別 | | | | | 負担  区分 | | | | 支給決定額  A＋D－B－C | | | | | | | | | | | | | |  | |
|  | |  | | |  | |  | |  | | | |  | | | |  | | | |  | | |  | | |  | | | |  | | | | 1入  2外  3食 | | | | |  | |  | | | |  | | |  | | |  | |  | | |  | |  | | |  | | | |  | |  | |  | |  | |  | |  | | 円 | |
| 保険診療金額 | | | | | | | | | | | | | | 法定負担額  A | | | | | | | | | | | | | | | | 附加給付額  B | | | | | | | | | | | | | | その他の控除  C | | | | | | | | | | | | | 薬剤一部  負担金　D | | | | | | | | | 本人負担額 | | | | | | | | | | | | | |
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| 重度障害者(児)医療費助成申請書  　年　　月　　日  　鯖江市長　　　　　殿    住所  申請者  (保護者)  氏名　　　　　　　　印 | | | | | | | | | | | | | | | | | | | | | | | | | | | | この欄は医療機関等へ申請する前に申請者が記入してください。この欄は医療機関等で記入してもらってください。 |
| 受給資格者 | 受給者証番号 | |  |  | |  |  |  | |  | |  |  |  | | |  |  | | 加入医療保険 | 発行機関名 | | |  | | | |
| (フリガナ) | |  | | | | | | | | | | | | | | | | | 保険種別 | | | 国保・退職・国組  ・協会・健組・共済・船員・その他 | | | |
| 氏名 | |  | | | | | | | | | | | | | 男・女 | | | |
| 負担区分 | | | 本人・家族 | | | |
| 生年月日 | | 年　　月　　日 | | | | | | | | | | | | | | | | | 付加給付等の有無 | | | 有　・　無 | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 保険医療機関等証明欄(領収書) | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 診療区分 | | 医科 | | | | | | | | | 歯科 | | | | | | | | | | | | 調剤 | | 柔整・ | | その他(　　) |
| 入院 | | | 入院外 | | | | | | 入院 | | | | | | | | 入院外 | | | |
| 年　　　　月分 | | | | | | | | | 診療実日数 | | | | | | | | | | | | | 日 | | | | | |
| 保険診療点数 | | 点 | | | | | | | 本人負担額 | | | | | | 円 | | | | | | | 薬剤一部負担額 | | | | 円 | |
| 入院時食事療養費標準負担額および入院時生活療養費標準負担額 | | | | | | | | | 月額　　　　　　　　　　　　　　　　円 | | | | | | | | | | | | | | | | | | |
| 上記のとおり証明する。  　　　　 　　年　　月　　日  医療機関等の所在地および名称  開設者氏名　　　　　　　　　　　　　　　　印 | | | | | | | | | | | | | | | | | | | | | | | | | | | |